TRICARE SUPPLEMENT PLAN ENROLLMENT FORM

For Retirees, Survivors and LTD Participants

Administered by: ASSOCIATION & SOCIETY INSURANCE CORPORATION
Sponsored by: American Military Retirees Association
Underwritten by: Monumental Life Insurance Company, Cedar Rapids, IA, an AEGON company

ASI ASSOCIATION & SOCIETY INSURANCE CORPORATION

☐ New Enrollment ☐ Add dependent(s)* ☐ Continue Coverage ☐ Change Address

Check the box below If you Are:	**Select your TRICARE option:**	**Policy #: MZ0925783H0000A** **Group Code: C9142-B DB** **Current Member ID # (LTD in waive status, provide Social Security No.):** **DEERS #:**
☐ Retired Military ☐ Retired Military Spouse ☐ Surviving Spouse of Retired Military ☐ Retired Reservist	☐ Standard ☐ Prime ☐ Retired Reserve	

Last Name:	First Name:	**Middle Initial:**
Street Address:	Date of Birth:	Telephone Number:
City:	State:	Zip Code:

LIST ALL DEPENDENTS TO BE ENROLLED IN THE PLAN

Relationship Code	Last Name	First Name	Middle Initial	Social Security Number	Date of Birth MM/DD/YYYY	If Child Disabled Check Y
Spouse						
Children						☐Y
						☐Y
						☐Y
						☐Y

The Coverage Level and Monthly Premium Amounts are as Follows:

More than (4) dependents, please add an extra sheet with their information

Member Only	$ 60.00
Member plus One	$ 119.00
Member plus Two/More	$ 160.00

AMRA dues of $1.00 is included in the monthly rates

[ ] Bill me monthly

[ ] Electronic fund transfer from my checking account

Relationship Codes

H=husband W=wife S=son D=daughter
SS=stepson SD=stepdaughter
OF=other female child OM=other male child

If you have more than 4 dependents, please attach an extra sheet with their corresponding code, name and Date of Birth

I hereby certify that the above statements are complete and true to the best of my knowledge. I hereby elect to apply for supplemental health insurance indicated under the TRICARE Supplement Plan, underwritten by Monumental Life Insurance Company.

AR, CO, KY, LA ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of a claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.
DC and RI Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FL Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of a claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. MD Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefits or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD. NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

I hereby enroll myself and/or my dependents with the Monumental Life and Accident Insurance Company for coverage under the American Military Retirees Association TRICARE Supplement Plan.

Return your completed form and documentation, if adding dependents to your coverage, to:
Commonwealth of Virginia
Department of Human Resource Management
Office of Health Benefits
101 N. 14th Street, 13th Floor
Richmond, Virginia 23219-3665

Sign Here	Retiree, Survivor or LTD Participant Signature:		Date:

Any questions, please call ASI at 1-866-637-9911

*Please provide documentation if adding dependents to your coverage. For more information, see Eligibility Rules and Definitions at www.dhrm.virginia.gov.